MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

SUMMARY

California's Medicare Rural Hospital Flexibility Program

California is participating in the Medicare Rural Hospital Flexibility Program (Flex Program), established by the Balanced Budget Act of 1997. The Centers for Medicare & Medicaid Services (CMS) has overall responsibility for the Flex Program. The Department of Health Services (DHS) receives the funds for this program. DHS entered into an Interagency Agreement with the Office of Statewide Health Planning and Development (the Office) to implement and administer California's Flex Program because of the Office's experience with rural hospitals. Due to the fact the Office did not have sufficient staff to handle the scope of work this program entails, the Office contracts with the California Health Foundation and Trust (the Contractor) to provide hospitals technical expertise not available within DHS of the Office. The Contractor is the non-profit entity of the California Healthcare Association (a statewide hospital association).

The Flex Program creates the Critical Access Hospital (CAH). A CAH is a limited service hospital that is eligible for a Medicare reimbursement rate that could be more attractive to some hospitals than their current reimbursement rate. The Flex Program components are maintaining a rural health plan, designating rural hospitals as critical access hospitals, development of rural health care networks, improvement of emergency medical services, quality of care, and evaluation.

Major Accomplishments

Rural Health Plan

- Three sections of the Medicare Rural Hospital Flexibility Program Rural Health Plan were updated:. Chapter 3, Section A. Emergency Medical Services; Chapter 3, Section G. Telemedicine; and Chapter 5, Section C. Department of Health Services, Primary Care Services. These revisions were approved by Region IX on May 15, 2001.

Critical Access Hospital Certification

Eight hospitals have been certified as a Critical Access Hospital:

- Avalon Municipal Hospital and Clinic

- Eastern Plumas District Hospital
- Glenn Medical Center
- John C. Fremont Hospital
- Mammoth Hospital
- Mayers Memorial Hospital
- Southern Inyo District Hospital
- Tehachapi Hospital

Two hospitals have been surveyed and are waiting for certification by the CMS Regional Office. These hospitals are Jerold Phelps Community Hospital, and Surprise Valley Community Hospital. Frank R. Howard Memorial Hospital will be surveyed for CAH certification in February, 2002. Biggs-Gridley Memorial Hospital and Corcoran District Hospital are preparing their application to be certified as a "Necessary Hospital" of health care services.

- Program Staff provided hospitals technical assistance (TA) to 26 hospitals considering applying for CAH/Necessary Provider certification. The Contractor developed a financial feasibility analysis template for hospitals to help them determine if their participation in the Flex Program would benefit them. Of the 26 hospitals likely to participate, 16 requested and received a financial analysis. Of those 16, ten submitted their application because of the positive results. A financial analysis was conducted for a rural hospital not on the list of potential CAHs, and because their analysis was positive, they submitted an application to be certified as a CAH.

- Soon after the Benefits Improvement and Protection Act of 2000 became law, the Contractor revised the financial feasibility template to incorporate the changes in the Flex Program that were included in the Budget Act of 2000. All of the eligible hospitals were then provided an opportunity to have their financial analysis redone. Fourteen hospitals requested a second analysis. The analysis for three of them showed an improvement

- Flex Program Staff assisted six hospitals prepare for their CAH surveys, and participated as an observer during the surveys to provide TA to the hospitals and the L&C surveyors. For example, during the survey of one hospital Staff assisted the administrator revise their transfer agreement to meet certification requirements which was then approved by the Surveyors. When a question arose about the interpretation of a CAH regulation, Staff assisted the L&C surveyors with resolving the question. An example of this is when a new Surveyor was informing hospital staff about the 96 hour length of stay, the Surveyor was not aware that the limitation had been changed to an annual average of 96 hours until the Flex Program staff explained the change.

- The Contractor provided hospitals information regarding reimbursement changes affecting hospitals that have a "provider-based" Rural Health Clinic and payment for long-term care services.

- Three economic impact studies were conducted by the Contractor for selected CAH communities in Inyo, Mariposa, and Modoc counties. The purpose of the studies was to determine what economic impact the closure of these hospitals would have on the surrounding communities of each CAH. This information may assist communities in their understanding of how much their hospital contributes to the health of the community and the local economy. A hospital could also use this information to strengthen their marketing strategy.

Rural Health Care Networks

- There were very few TA requests for network development. Staff assisted nine hospitals with transfer agreements and assessment of the various types of networks (e.g., vertical and horizontal) appropriate for a new CAH. In rural communities, developing a health care network requires more time than most rural health providers are willing to dedicate to this effort. One factor that prevents health care providers and communities from being more interested in developing health care networks is the time it takes for them to acquire the trust needed for developing a network that is more than the minimum required for the Flex Program (transfer agreements with another hospital constitutes a CAH network).

- The Contractor assisted a certified CAH and a hospital in neighboring county with their efforts to merge. This merger was directed at improving economies of scale rather than enhancing access to tertiary services. One of the anticipated outcomes of this effort was being able to develop a network model for replication in other communities. After several months of trying to work out a merger, the two facilities were not able to settle their differences on enough of the merger issues to enter into a merger agreement.

- Most of the hospitals participating in the Flex Program had conducted a community health care needs assessment prior to being certified. Only one hospital requested assistance with their needs assessment. The Contractor provided TA to the hospital's health educator who conducted the needs assessment. Staff continues to encourage CAHs and potential CAHs to keep abreast of the health care needs of the communities they serve.

Emergency Medical Services

The major activities in emergency medical services (EMS) were training and providing CAHs grants to purchase equipment.

- The use of CAH grant funds for training was focused on providing three training courses (on-site) to certain CAHs located in the Northern California EMS region (consisting of 11 counties) encompassing approximately 33,000 square miles in that sector of the state.

  1) The first course was "Hospital Emergency Incident Command System. This course is considered by the California EMS Authority and California Department of Health Services as the premier management system for responding to internal and external disasters.
  2) The second course was "Pediatric Respiratory Emergencies and Shock: Penetrating Trauma" was offered because providers at various levels expressed a need for this type of training when treating pediatric patients.
  3) A different approach was used in presenting the third course, "Pediatric Respiratory Failure and Shock". This course was professionally video taped and will be distributed to the CAHs in that region, and if successful, perhaps it will be sent to the other CAHs as well.

  Eight hospitals were awarded grants for minor remodeling, to purchase equipment such as:
  - a computer system and patient education software package for the emergency room;
  - pagers for emergency on-call staff;
  - IVAC infusion pump for the emergency room;
  - oxygen concentrator;
  - a computer for the emergency room;
  - payroll software to improve cost reporting; and
  - a printer for ultrasound machine; etc.

  Flex Program Staff and the Contractor continue to encourage CAHs to accelerate their efforts to establish/expand programs to improve or integrate EMS into their networks. Because most of the CAHs are very much involved in the regional EMS system, hospitals do not have EMS activities as a priority in their strategic plan.

  Quality Assurance/Improvement

  The Contractor sub-contracted with the California Institute for Health Systems Performance to provide quality improvement consulting to critical access hospitals. A quality improvement project was implemented to improve care provided to pneumonia and congestive heart failure patients through the implementation of evidence-based practice guidelines. Standardized data collection forms were used to collect data from 17 (of the 26 potential critical access hospitals) that volunteered to participate in this project.

  The data related to pneumonia and congestive heart failure diagnoses were selected for this study because they represent a relatively high volume for a

CAH and the data can be easily identified and translated into patient care improvements. This study indicates that CAHs have opportunities for improvement. Individual consultation was made available for those who desired additional assistance with their improvement activities. A "Hospital Quality Improvement Toolkit" was made available to those who did not already have it, and tools and guidelines (from the American Heart Association) were made available to all participants in the study.

Evaluation

The first phase of the CAH evaluation effort in California relates to the implementation of the Flex Program in the field and to determine the value of this Program to the hospitals. The Contractor conducted the first evaluation effort to:

- provide an initial review of the CAHs and their activities to date;
- establish a baseline from which to measure successes and failures in the future; and
- begin to understand the issues and constraints surrounding those successes and failures.

The baseline data was collected from three groups of CAHs or CAH eligible hospitals: hospitals with several months of CAH experience; Hospitals that have recently entered the program or are actively in the process of entering the program; and hospitals which have not (yet) decided to become a CAH.

The preliminary findings indicate that the CAH program will infuse more cash into several facilities and will exempt CAHs from complicated reimbursement and billing systems similar to the Medicare outpatient prospective payment systems. A comparison of the anticipated additional revenue from becoming a CAH with an amount needed to break even indicates that half of the facilities studied would not gain enough from CAH status to break even.

As stated by the Contractor, "the CAH program is not a panacea" for rural hospitals struggling to survive. Nor will the benefits of CAH status overcome problems related to administration, medical staff, governance, billing practices and staffing. The Contractor states that "the program will not significantly ameliorate the effect of the lack of economies of scale on small low-volume facilities. CAHs will have to be operated efficiently and effectively, which includes adhering to sound business practices in order to continue operations. However, the program does provide for both reimbursement and billing system improvements that can be used to allow an already efficient operation to gain financially from those efficiencies. This would allow such a hospital to better service the needs of its community."

Phase two of evaluating the success of the CAHs will take place during the 2001/2002 contract period. The tool for evaluating the State's operation of the Flex Program is being developed during the current grant period.